PromptMD URGENT CARE CENTER

HOBOKEN'S PREMIER URGENT CARE CENTER WWW.PROMPTMD.COM

INFLUENZA VACCINE (FLU SHOT) CONSENT FORM 2014-2015

1. **Have you ever had an allergic reaction to flu vaccine?** **Yes or No**
2. **Are you allergic to eggs or egg products?** **Yes or No**
3. **Do you have a history of Guillain-Barre Syndrome? (Illness associated with the swine flu in 1976 characterized by fever, nerve damage, and muscle weakness)** **Yes or No**
4. **Are you allergic to Thimerosal (a mercury-based preservative)?** **Yes or No**
5. **Are you allergic to latex?** **Yes or No**
6. **Do you feel ill today or do you have a fever?** **Yes or No**

Heard about the office from: (Circle ones that apply) **Newspaper / Physician / Hospital / Street Sign / Employer / E-mail Store Advertisement / Friend or Relative / Other _____**

I hereby certify that the foregoing history is true and complete to the best of my knowledge and I have received and read the "Vaccine Information Statement" from the CDC, have had an opportunity to ask questions that were answered to my satisfaction, and do wish to receive the flu vaccination fully understanding the risks and the benefits. I hereby consent to the administration of the flu vaccine (flu shot). Furthermore, I hereby release and forever discharge for myself, my heirs, executors, administrators and assignees, **PromptMD** and their employees, owners and representatives from any and all claims, demands, actions and causes of action, which may result from participation in this program.

Your personal information and results shall be held strictly confidential.

PARTICIPANT INFORMATION AND CONSENT

LAST NAME:	**FIRST NAME:**	**MI:**	
ADDRESS:	**CITY:**	**STATE:**	**ZIP:**
PHONE:	**E-MAIL:**		
BIRTHDATE:	**AGE:**		
SIGNATURE:		**DATE:**	

FOR OFFICE USE ONLY

MANUFACTURER AND LOT#: Sanofi Pasteur LOT# UI185AB
EXPIRATION DATE: 06/30/2015
SITE OF INJECTION: R / L DELTOID
COMMENTS:
SIGNATURE AND TITLE OF VACCINE ADMINISTRATOR: